DETAILED ANALYSIS: THE COSTS OF HOUSE DEMOCRATS' HEALTH BILL

The more the American people learn about the government takeover of health care proposed by Speaker Nancy Pelosi and her congressional allies, the more they oppose it. Tucked in the more than 1,000-page bill House Democratic leaders put together are hundreds of provisions that will increase health care costs, hurt small businesses, destroy jobs, lead to rationing patient care, raise taxes on families and small businesses, create a massive new federal bureaucracy, break President Obama's promises, and provide giveaways to special interests. Following are highlights of those provisions:

HOW THE HOUSE DEMOCRATS' BILL WILL LEAD TO HIGHER COSTS THROUGH A GOVERNMENT TAKEOVER OF HEALTH CARE

Despite what President Obama and congressional Democrats say, their bill would increase health care costs rather than lower them by pushing a government takeover of health care. Here are just a few examples how:

Pages 116-118; Section 221 – Requires the Secretary to establish a government run plan that is supposed to play by the same rules as private plans in the exchange. The bill, however, requires the government to set the benefits of all of the plans, including its own creating an implicit unlevel playing field by allowing the government to set rules for itself.

Page 120, lines 4-21; Section 222 – Gives $2 billion and as much money as is needed to pay claims for 90 days from the Treasury to the government plan. While it requires the government run plan to repay the money, it only requires the plan to repay the money over ten years – and without any interest payments. This gives the public plan an enormous capital advantage over private plans.

Page 124, lines 24-25; Section 223 – This section shelters the government plan from any administrative or judicial review of any payment rate or methodology it uses. No company can sue the government for price fixing.

Page 118, lines 14-22; Division A, Section 221(g) – Unlike private insurance plans, who can be sued in state courts, the government-run plan could only be sued in federal court. This affords the government plan significant advantage over the plans it is supposed to "compete" against.

Pages 41-47; Division A, Sections 141 and 143 – House Democrats would establish a new government-run "Exchange," through which a new government-run plan would offer coverage alongside private plans. The Exchange would be run by a new "Health Choices Commissioner," who is nominated by the President and confirmed by the Senate. As the Commissioner is serving at the pleasure of the President, some may be concerned about the lack of independence of this individual. The Commissioner would also be required to work with the Secretary of HHS, creating the potential for a serious conflict of interest that could significantly disadvantage

the private health plans where more than 170 million Americans currently receive their health coverage.

HOW THE HOUSE DEMOCRATS' BILL WILL LEAD TO RATIONING CARE

Patients and doctors, not government bureaucrats, should make medical decisions. But the House Democrats' bill puts bureaucrats in charge. Here are just a few examples:

Page 30; Section 123 – The bill establishes a Health Benefits Advisory Committee to make determinations including "categories of covered treatments, items and services within benefit classes and cost sharing."

Page 122; Division A, Section 223(a)(4) – The Secretary of HHS would decide which prescription drugs are made available in the government plan. Evidence has shown that government officials in other countries have used this power to deny access to needed treatments on the basis of cost.

Page 84; Section 203 – This section requires the Commissioner to specify what benefits can be made available under plans in the Exchange, rationing care for those in the plans.

Page 85; Section 203, line 7 – The bill sets benefit levels for the plans in the exchange. Of the four plan types permitted by the bill, the government will dictate what benefits will be allowed and in fact mandates that three of the four types have exactly the same benefits.

Pages 116-128; Division A, Title II, Subtitle B – The bill establishes a new government-run plan which would pay hospitals and doctors at Medicare rates for their services. Given that Medicare significantly underpays providers, private plans would be left to pick up the slack. As a result, the average cost of private coverage for a family of four would be nearly $4,000 more expensive because of the cost-shift. Those with private plans will subsidize those in government plans.

Page 122; Section 223, lines 14-17 – Requires the Secretary in the government run plan to negotiate drug prices directly for drugs not covered by Medicare. This will impose price controls and eliminate competition in the market, a key reason why prices under Medicare Part D have decreased.

Multiple Sections, e.g. Sections 112, 113, 116, 121, 122, 123, 124 – Requires private insurers to comply with new coverage and underwriting rules in order to offer insurance products both inside and outside of the new national and state insurance exchanges.

Page 253; Section 1122, lines 10-18 – The government, in creating a process to "validate relative value units" in the physician payment schedule, will weigh and determine what aspects of what physicians do matters. For example, is time, mental effort, professional judgment, technical skill, or physical effort more important in determining how much a physician should be paid for a service?

Page 26; Section 121(c) – prohibits any health plan restriction "unrelated to clinical appropriateness" (which is not further defined). This would likely restrict care of military members that are related to military mission requirements separate from what might be an eventual administrative definition of "clinical appropriateness."

HOW THE HOUSE DEMOCRATS' BILL RAISES TAXES ON FAMILIES & SMALL BUSINESSES

In the midst of an economic recession when thousands of jobs are being lost, the last thing families and small businesses need are higher taxes. Yet the House Democrats' bill would do just that. Here are just a few examples:

Pages 179-188; Division A, Title III, Subtitle A, pages 143-167, and Pages 197-204; Division A, Title IV, Part II, Subtitle D, Sec. 441 – Massive new taxes included in the bill would devastate the economy, put millions of Americans out of work, and make it hard for others to find work. Using the same methodology developed by Dr. Christina Romer, Chair of the Council on Economic Advisors, and Jared Bernstein, Chief Economist and Economic Policy Adviser to Vice President Joseph Biden, these sorts of a tax increases would result in as many as 5.5 million Americans losing their job.

Pages 149 and 183; Sections 313 and 412 – The bill imposes a new eight percent payroll tax on: Employers who can't afford to offer health insurance to their employers; Employers who do the right thing and offer health coverage to their employees but it's deemed "insufficient" by the government; Employers who offer "sufficient" coverage but the employee enrolls in coverage elsewhere (e.g. coverage through a spouse's employer); and Employers who aren't paying at least 72.5 percent of an employee's premium (65 percent for family coverage).

Pages 823-835; Division B, Section 1802 – The bill would establish a new tax on every health insurance policy to fund a government board that would be tasked with deciding which treatments are more cost-effective. The research findings would be used by the government to ration care. This new tax will increase the cost of health insurance for every American not on Medicare or Medicaid.

Pages 167-169; Division I, Title IV, Section 401 – New Tax on Individuals of almost 2.5 percent of their income if they don't purchase health insurance the government deems acceptable.

Page 167; Section 401 – President Obama stated during the presidential campaign that "Middle class families will see their taxes cut – and no family making less than $250,000 will see their taxes increase." Yet, section 401 (individual mandate) violates the President's pledge by taxing families making less than $250,000 per year.

Page 194; Section 431 & Page 820, Section 1801 – There are two provisions in the bill allowing for disclosure of otherwise confidential taxpayer information. One allows the Health Choices

Commissioner to calculate subsidy levels and one allows the Social Security Administration to do outreach for the prescription drug program.

Page 197; Section 441 – The surtax takes effect starting in 2011, but the low-income subsidies for health care start in 2013 and grow rapidly thereafter. This means that, on a year-by-year basis, the bill is not fully paid-for, raising real concerns about the long-term impact of this proposal on the deficit.

Page 204; Section 442 – The proposal delays, but does not repeal, new worldwide interest allocation rules. This particular revenue raiser sunsets at the end of the 10-year window, but there are no spending provisions in the bill that sunset at the end of the 10-year window meaning there is yet another mismatch between spending and revenues in the future.

Page 204; Section 451 – Section 451 targets "insourcing" companies – firms that are headquartered abroad but that have U.S. subsidiaries that support good jobs here in America – with higher taxes. This provision could lead to lower investment in the U.S. by foreign companies, which could reduce American jobs.

HOW THE HOUSE DEMOCRATS' "COST CONTROL" MEASURES FAIL TO CONTROL HEALTH CARE COSTS

The House Democrats' bill includes numerous provisions supposedly designed to "control costs" but in fact it is largely just more of the same. Here are just a few examples:

Page 128; Division A, Section 226 – House Democrats require the government-run plan to adopt Medicare's fraud "enforcement" measures. The success of those measures is debatable at best. Consider, for example, that the Chief Counsel for the HHS Office of Inspector General recently said that criminals have decided that building a Medicare fraud scam is far safer than dealing in crack or dealing in stolen cars, and it's far more lucrative.

Pages 24-25; Division A, Section 116, and pages 53-55; Division A, Section 161 – The House Democrats' bill creates a perverse and harmful incentive for health plans to keep their members sick by requiring a percentage of premium dollars, as determined by the Commissioner, be spent health care claims rather than on disease management, 24 hour nurse help lines, etc, that keep people healthy.

Pages 89-95; Division A, Section 204(b) – Provider reimbursement reforms within the Exchange are optional, meaning the health care system will continue to reward hospitals and physicians who order more services rather than those who deliver high-quality care. Experts across the political spectrum agree that the key to controlling health care spending growth is to correct misaligned payment incentives. The House Democrats bill is just more of the same.

Pages 358-369; Division B, Section 1181(b) – House Democrats make significant changes to Medicare Part D, jeopardizing the continued success of the program. Largely due to private

market competition, Part D program costs are 40 percent below initial estimates. Yet the Democrats want to extend government price controls to the Part D program via Medicaid rebates.

HOW THE HOUSE DEMOCRATS' BILL HURTS SMALL BUSINESSES & JOBS

Small businesses don't fare well under the House Democrats' bill, whether it is new tax hikes, new fines, or new government mandates. Here are just a few examples:

Page 21; Section 113 – The bill requires the Commissioner to conduct a study on the large group and self-insured markets and further requires that the study examine the "financial solvency and capital reserve levels" of employers that self-insure and their risk of "not being able to pay obligations or otherwise becoming financially insolvent."

Page 157; line 22; Division A, Section 321 (b)(2)(C)(iii)(II) – This section imposes fines of up to $500,000 on employers who make an honest mistake, thinking they had provided what the government deemed "sufficient" coverage.

Page 155; Division A, Section 321 (b)(2) – This section imposes fines of $100 per employee per day on employers who do not offer a level of health coverage that is "government-approved" (employers would pay this fine every day until the oversight is corrected).

Page 189; lines 6-12; Division A, Section 421 (b)(2) – Under the bill, small businesses could receive subsidies to cover a portion of their health care costs. However, to receive a full subsidy, the average employee income must be below $20,000 and have fewer than 10 employees. This creates a perverse incentive to keep wages low and to not hire new workers.

Page 150; lines 9-13; Section 313 – The bill includes a "small business exclusion" from the eight percent payroll tax, but the definition of small business in the bill leaves a large number of small businesses subject to the full eight percent tax. In fact, on average, small businesses with as few as 12 employees would be subject to a new payroll tax through the bill if they could not afford to provide coverage. Worse, the bill does not index to inflation the amounts which trigger the "small business exemption" meaning that Democrats have built into the bill a mechanism that capture and subject more and more small employers to the eight percent tax over time.

Page 198; lines 19-24; Section 441 – If the government does not realize savings the authors of the bill claim will occur – even though congressional scorekeepers did not project any savings from these provisions – then the national small business surtax is automatically increased.

Page 144-149; Division A, Title III, Subtitle B, Part 1, Section 312 – The bill mandates that employer contributions cannot come through salary reductions. Under this section, employers have to make a minimum contribution toward the health benefits plan premium for both full-time and less than full-time employees. By the terms of this provision, they cannot take that contribution out of an employee's salary. That defies logic since any contribution that an employer makes toward a health care premium is necessarily money it cannot pay to its employees in salary.

HOW THE HOUSE DEMOCRATS' BILL WILL RESULT IN FEDERALLY MANDATED AND SUBSIDIZED COVERAGE OF ABORTION

Page 24; Section 115 – This section requires that plans that use a provider network for health services must meet the standards set forth by the Commissioner to assure the adequacy of the network for plan enrollees to receive covered services. If abortion becomes an essential benefit, as Section 122 leaves open as a possibility, provider networks would be required to ensure – including by establishing abortion clinics – that abortion services are available.

Page 26; Section 122 – This section defines what would be deemed an "essential benefits package," or in other words what the government sets as benefits or services that must be covered by an insurance plan. This section, however, contains no explicit exclusion or prohibition from abortion being deemed part of an essential benefits package. Without such an exclusion, the bill leaves open the possibility of federally mandated coverage of abortion as an essential benefit.

H.R. 3200 does not contain any limitation on federal funds authorized or appropriated in the bill from being used to pay for elective abortion or to subsidize the purchase of insurance coverage of elective abortion.

HOW THE HOUSE DEMOCRATS' BILL ELIMINATES CHOICES FOR PATIENTS

The House Democrats' bill eliminates choices for patients, undermining their rights at the expense of government bureaucrats. Here are just a few examples:

Page 97; line 20; Section 205 – This section requires the Commissioner to automatically enroll exchange-eligible individuals into a government sanctioned plan with rationed care. The bill says the Commissioner should enroll people in to plans through a "random assignment." In reality, the Commissioner will enroll these people onto the government run plan. Because the Commissioner can auto enroll exchange eligible individuals who have not elected coverage to any plan in the exchange, this provision is a defacto method for signing millions of Americans up for the government run plan.

Page 102; lines 12-18; Section 205 – This section requires that the Commissioner enroll Medicaid eligible individuals who have not elected to be part of the program into Medicaid.

Page 115, lines 4-12; Section 208 – This section allows states to establish their own exchange or join together with other states in a multi-state exchange. The bill, however, also gives the Commissioner the authority to tell states what their state or multi-state exchanges can and cannot do.

Page 137; Division B, Title VII and Division I, Title II, Subtitle C – Expands Medicaid eligibility to all individuals up to 133 percent of poverty and "low income" subsidies can go to a

family of four making more than $88,000. This will shift even more Americans onto the government rolls.

Page 167; Section 401 – When you file your taxes, if you can't prove to the IRS that you are in a qualified plan, you'll be forced to pay almost 2.5 percent of your income in new taxes or face additional penalties.

Page 424-430; Section 1233(a)(1)(B) – One troubling provision of the House bill compels seniors to submit to a counseling session every five years (and more often if they become sick or go into a nursing home) about alternatives for end-of-life care. The sessions cover highly sensitive matters such as whether to receive antibiotics and "the use of artificially administered nutrition and hydration."

Page 16, lines 20-26; Section 102(a)(2) – While the bill allows individuals to stay in "grandfathered" private plans they may have now under certain circumstances, as soon as anything changes in the plan – such as a change in co-pay or deductibles or even added benefits or coverage of a new life-saving drug or treatment, which many insurers change every year – you will be forced out of that coverage and be forced into a government-approved qualified plan instead.

Page 145, lines 15-17; Section 312 – This section of the bill requires employers to auto-enroll their employees regardless of the employees' choice.

Page 146, lines 3-13; Section 312 – This section not only requires employers to provide coverage for their employees that the government deems "acceptable" but it also requires that employers pay for a specific amount of the employees' premium costs – 72.5 percent for individual plans and 65 percent of family plans – or pay a new 8 percent tax.

Page 9, lines 7-24; Section 100(c)(6) – This section defines "employment-based health plan" as including governmental plans, which includes TRICARE . It then provides a 5 year grace period for current employment-based health plans (section 102(b)(1)(A) (page 17) before the plan has to meet the requirements of a qualified health benefits plan under section 101. Section 101 provides that qualified health benefits plans must meet the requirements of subtitle B (relating to affordable coverage), subtitle C (relating to essential benefits), and subtitle D (relating to consumer protection). This means that the bill would subject TRICARE to any future requirements on employer based health plans.

Pages 26-27; Division A, Title I, Subtitle C, Section 122 – The bill requires that benefits must be equivalent to average prevailing employer coverage. By requiring that the future "essential benefits package" of any "qualified health benefits plan" include benefits equivalent to the current prevailing average employer-sponsored coverage, section 122(a)(5) necessarily raises the average scope of health benefits covered by future health plans. Businesses will not be free to vary the mix of benefits available to see which ones attract employees best; instead, they will have to offer a certain minimum level of health benefits regardless of the demonstrated preferences of their employees (for higher salaries in lieu of pricier health benefits for example).

HOW THE HOUSE DEMOCRATS' BILL BREAKS PRESIDENT OBAMA'S PROMISES

The House Democrats' bill breaks a number of President Obama's promises. Here are just a few examples:

Pages 116-128; Division A, Title II, Subtitle B – This section establishes a new government-run health plan that, according to non-partisan actuaries at the Lewin Group, would cause as many as 114 million Americans to lose their existing coverage. Moving these Americans from their current plan into a government-run plan violates the President's oft-stated pledge to let people keep their current coverage if they like it.

Pages 331-333; Division B, Section 1161 – Nor would this promise appear to apply to millions of seniors who are enrolled in Medicare Advantage (MA). As many as 3 million seniors would lose their Medicare Advantage coverage if the Democrats' $160 billion Medicare Advantage cuts are enacted.

Pages 167-179; Division A, Section 401 – The President also repeatedly promised not to raise taxes on those who make less than $200,000 (singles) or $250,000 (married couples). The tax on Americans without health insurance in this bill directly violates that promise.

At least four of President Obama's pledges to not raise taxes would be broken by the House Democrats' government health care takeover bill. The president pledged that 1) "no family making less than $250,000 will see their taxes increase," and that families making more than $250,000 will 2) "pay either the same or lower tax rates than they paid in the 1990s," 3) be subject to a "new [higher] top capital gains rate of 20 percent" and 4) have a dividends tax rate "set at 20 percent." Yet, the Democrats' bill imposes an individual mandate that would raise taxes on some American families earning less than $250,000 (Division A, Section 401 pgs 167-179), imposes a national small business tax (in conjunction with the President's expiration of lower marginal rates) that will take the top federal tax rate well above where it was in the 1990s, and apply the national small business tax to capital gains and dividends sending those tax rates to 25.4 percent and 45 percent respectively.

HOW THE HOUSE DEMOCRATS' BILL PROVIDES GIVEAWAYS TO SPECIAL INTERESTS

Written with the help of special interests, it's easy to understand why the House Democrats' bill provides numerous giveaways to special interest groups and their allies. Here are just a few examples:

Page 65; Section 164 – This section creates a $10 billion reinsurance program for retirees and their families and dependants, as well as union or association plans which will subsidize these plans' costs by 80 percent, or up to $60,000 per insurance plan.

Page 95; Section 205, lines 8-18 – Section 205 directs the Commissioner to conduct outreach activities, including through the use of outside organizations such as ACORN and others, to reach out and enroll exchange-eligible individuals and employers.

Page 31-32; Division A, Title I, Subtitle C, Section 123(a)(5) – The bill requires that the Health Benefits Advisory Committee include labor unions. This advisory committee would be charged with recommending covered benefits for essential, enhanced, and premium plans. Although the reference to 'labor' does not necessarily require a union representative or a unionized employee on the committee, the choice of that word as opposed to 'employees' suggests that organized labor is assured a position on the advisory committee.

Page 53; Division A, Title I, Subtitle F, Section 154 – This language ensures that the new federal health care program will set a floor (but not a ceiling) for health care negotiations for unionized employers. The legislation cannot be construed to excuse them from good-faith bargaining over health care benefits. Furthermore, the federal legislation will not permit unionized employers to unilaterally drop health coverage of its employees in favor of shunting them into the federal plan or simply paying the penalty associated with not offering health care benefits to workers.

Page 270; Division B, Title I, Subtitle B, Part 3, Sec. 1144(a)(1) – This section requires cost reporting by ambulatory surgical centers (ASCs), with specific reporting requirements to be determined by the HHS Secretary. If she chose to require reporting on the number, type and cost of nurses employed in a facility, as is the case in other sections of the bill, these reports would be useful roadmaps for labor organizations trying to organize a facility or collectively bargain.

Page 524-533; Division B, Title IV, Subtitle B, Part 1, Sec. 1411 – This section contains multiple mandates requiring nursing homes to report information publically that would be useful to labor organizations trying to unionize nursing home employees. By disclosing the names and titles of its 'managing employee[s]' as well as how they relate to one another on the organization chart, a nursing home will reveal which of its employees are not managers. In so doing, the nursing home would effectively indicate that unlisted employees are subject to unionization.

Pages 533-551; Division B, Title IV, Subtitle B, Part 1, Sec. 1412 – This section requires the Comptroller General of the U.S. to conduct a study examining: "(A) The extent to which corporations that own or operate large numbers of nursing facilities … are undercapitalizing such facilities. (B) The effects of such undercapitalization on quality of care, including staffing and food costs, at such facilities. (C) Options to address such undercapitalization, such as requirements relating to surety bonds, liability insurance, or minimum capitalization." This provision primarily benefits trial lawyers who sue nursing homes, but such a study by GAO could also set the stage for regulations requiring increased staffing levels.

Pages 551-569; Division B, Title IV, Subtitle B, Part 1, Sec. 1413 – This section requires HHS to include certain kinds of information about nursing home facilities and skilled nursing facilities on its website, including staffing, turnover, and tenure data for each facility. It also requires the Secretary to consult with labor unions representing workers at the facility in reviewing the information. By giving labor unions a voice in deciding what information will appear on the website, the bill creates an opportunity for the unions to drive their staffing or other agendas.

Pages 569-571; Division B, Title IV, Subtitle B, Part 1, Sec. 1414 – This section requires cost reports submitted by skilled nursing facilities to "separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff)." Such detailed cost reporting pertaining to wages would be very useful to unions for collective bargaining and/or labor organization purposes. The information could also be used to dispute claims about which employees are genuinely serving in a supervisory capacity.

Pages 584-587; Division B, Title IV, Subtitle B, Part 1, Sec. 1416(a) and (b) – This section also requires detailed staffing and employee information to be submitted for public inspection. This kind of detailed information would help labor organizations to unionize particular facilities and to benchmark salaries at unionized facilities against those at non-unionized facilities. Separate information on contract staff would also allow labor unions to gather data to bargain (or lobby) against the use of contract staff at such facilities.

Pages 1007-1017; Division C, Title V, Subtitle D, Sec. 2531 – H.R. 3200 establishes labor union grants for the training of nurses. Section 2531(b) (Page 1008, lines 4-12) of the bill establishes a partnership grant program to award grants for collaborative programs between staff nurse organizations, health care providers, and accredited schools of nursing. Except for nursing schools, entities must work with labor unions in order to meet the eligibility requirements for receiving grant funds. Not only do these grants have to go to joint union-run programs (unless they go directly to nursing schools), but section 2531(d)(1)-(3) (Pages 1010-11) further restricts eligibility to a health care employer pay prevailing wages and subsidize the costs of their employees' participating in these training programs will be able to receive grants. To the extent the grant program is effective, nursing shortages will become worse in non-unionized hospitals than in unionized hospitals. These training programs will also provide unions with access to future nurses before they even complete their training, which could make it easier for the unions to organize those nurses in the future—either because of gratitude for the union's involvement in providing their training, or else simply due to their early access to the employees.

HOW THE HOUSE DEMOCRATS' BILL GIVES UNCHECKED POWER TO A NEW "HEALTH CARE CHOICES COMMISSIONER"

The House Democrats' bill gives uncheck power to a new "Health Care Choices Commissioner." This is extremely troubling given the large scope of responsibility given to the Commissioner. In fact, the Commissioner is so powerful that the title is referenced 182 times in the House Democrat's bill. This government official would have the power to:

1. Decide which treatments patients could receive and at what cost; (Division A, Section 203 pg 84-87)

2. Decide which privates plans would be allowed to participate in the Exchange; (Division A, Section 142(a)(1) pg 42)

3. Regulate all insurance plans, both in and out of the Exchange; (Division A, Section 134 pg 40)

4. Determine which employers would be allowed to participate in the Exchange; (Division A, Section 202(e)(3) pg 80)

5. Determine how many Americans will be allowed choose health coverage through the Exchange; (Division A, Section 202(f) pg 82)

6. Decide which physicians and hospitals participate in the government-run plan and in private plan provider networks; (Division A, Section 204(b)(6) pg 90)

7. Determine which states are allowed to operate their own Exchange and to terminate a previously-approved State Exchange at any time; (Division A, Section 208 pgs 111-115)

8. Override state laws regarding covered health benefits; (Division A, Section 203(d) pg 87)

9. Determine how trillions of taxpayer and employer dollars would be spent within the Exchange; (Division A, Section 142(a)(2) pg 42)

10. Determine who qualifies for premium assistance; (Division A, Section 142(a)(3) pg 42)

11. Automatically enroll Americans into the Exchange if they don't have coverage, including potentially forcing these individuals into the government-run plan. (Division A, Section 205(b)(3) pgs 97-99)

HOW THE HOUSE DEMOCRATS' BILL UNDERMINES HEALTH CARE PROVIDED BY SMALL BUSINESSES & EMPLOYERS

The House Democrats' bill erodes the ability of small businesses and other employers to exercise their rights and obligations under the Employee Retirement Income Security Act **(**ERISA**)** to provide benefits tailored to their own workforce. Here are just a few examples:

Section 142 – The House bill says that after a five-year grace period all ERISA insurance offerings will have to win government approval—both by the Department of Labor and a new "health choices commissioner" who will set federal standards for what is an acceptable health plan. The commissioner can fine employers that don't comply and even has "suspension of enrollment" powers for plans that he or she has vetoed, until "satisfied that the basis for such determination has been corrected and is not likely to recur."

Section 261 – This section, included in the Chairman's Amendment in the Nature of a Substitute at the Education and Labor Committee markup, provides for automatic federal waivers to ERISA for states that enact single-payer health care systems. Waivers to ERISA would preclude employers from offering consistent benefits. The practical effect of this section is that workers

receiving health coverage from the same employer in different states could have wide disparities in coverage.

Sections 132 and 151 – These two sections provide for unlimited state law remedies for employer-sponsored health coverage obtained through health insurance exchanges. Litigation will increase under this provision, further driving up the cost of health insurance for millions of Americans.

Section 165 – This section, included in the Chairman's Amendment in the Nature of a Substitute at the Education and Labor Committee markup, prohibits one of the core principles of ERISA, the voluntary nature of employee benefits, by imposing a prohibition on modifications to retiree health plans.

HOW THE HOUSE DEMOCRATS' BILL CREATES MASSIVE NEW BUREAUCRACY

The House Democrats' bill creates a massive new federal bureaucracy littered with new federal agencies, new programs, and new bureaucrats. Here they are:

1. Health Benefits Advisory Committee (Section 123, p. 30)
2. Health Choices Administration (Section 141, p. 41)
3. Qualified Health Benefits Plan Ombudsman (Section 144, p. 47)
4. Program of administrative simplification (Section 163, p. 57)
5. Retiree Reserve Trust Fund (Section 164(d), p. 70)
6. Health Insurance Exchange (Section 201, p. 72)
7. Mechanism for insurance risk pooling to be established by Health Choices Administration Commissioner (Section 206(b), p. 106)
8. Special Inspector General for the Health Insurance Exchange (Section 206(c), p. 107)
9. Health Insurance Exchange Trust Fund (Section 207, p. 109)
10. State-based Health Insurance Exchanges (Section 208, p. 111)
11. "Public Health Insurance Option" (Section 221, p. 116)
12. Ombudsman for "Public Health Insurance Option" (Section 221(d), p. 117)
13. Account for receipts and disbursements for "Public Health Insurance Option" (Section 222(b), p. 119)

14. Telehealth Advisory Committee (Section 1191, p. 380)

15. Demonstration program providing reimbursement for "culturally and linguistically appropriate services" (Section 1222, p. 405)

16. Demonstration program for shared decision making using patient decision aids (Section 1236, p. 438)

17. Accountable Care Organization pilot program (Section 1301, p. 443)

18. Independent patient-centered medical home pilot program under Medicare (Section 1302, p. 462)

19. Community-based medical home pilot program under Medicare (Section 1302(d), p. 468)

20. Center for Comparative Effectiveness Research (Section 1401(a), p. 502)

21. Comparative Effectiveness Research Commission (Section 1401(a), p. 505)

22. Patient ombudsman for comparative effectiveness research (Section 1401(a), p. 519)

23. Quality assurance and performance improvement program for skilled nursing facilities (Section 1412(b)(1), p. 546)

24. Quality assurance and performance improvement program for nursing facilities (Section 1412 (b)(2), p. 548)

25. Special focus facility program for skilled nursing facilities (Section 1413(a)(3), p. 559)

26. Special focus facility program for nursing facilities (Section 1413(b)(3), p. 565)

27. National independent monitor pilot program for skilled nursing facilities and nursing facilities (Section 1422, p. 607)

28. Demonstration program for approved teaching health centers with respect to Medicare GME (Section 1502(d), p. 674)

29. Pilot program to develop anti-fraud compliance systems for Medicare providers (Section 1635, p. 716)

30. Medical home pilot program under Medicaid (Section 1722, p. 780)

31. Comparative Effectiveness Research Trust Fund (Section 1802, p. 824)

32. "Identifiable office or program" within CMS to "provide for improved coordination between Medicare and Medicaid in the case of dual eligibles" (Section 1905, p. 852)

33. Public Health Investment Fund (Section 2002, p. 859)

34. Scholarships for service in health professional needs areas (Section 2211, p. 870)

35. Loan repayment program for service in health professional needs areas (Section 2211, p. 873)

36. Program for training medical residents in community-based settings (Section 2214, p. 882)

37. Grant program for training in dentistry programs (Section 2215, p. 887)

38. Public Health Workforce Corps (Section 2231, p. 898)

39. Public health workforce scholarship program (Section 2231, p. 900)

40. Public health workforce loan forgiveness program (Section 2231, p. 904)

41. Grant program for innovations in interdisciplinary care (Section 2252, p. 917)

42. Advisory Committee on Health Workforce Evaluation and Assessment (Section 2261, p. 920)

43. Prevention and Wellness Trust (Section 2301, p. 932)

44. Clinical Prevention Stakeholders Board (Section 2301, p. 941)

45. Community Prevention Stakeholders Board (Section 2301, p. 947)

46. Grant program for community prevention and wellness research (Section 2301, p. 950)

47. Grant program for community prevention and wellness services (Section 2301, p. 951)

48. Grant program for public health infrastructure (Section 2301, p. 955)

49. Center for Quality Improvement (Section 2401, p. 965)

50. Assistant Secretary for Health Information (Section 2402, p. 972)

51. Grant program to support the operation of school-based health clinics (Section 2511, p. 993)

52. National Medical Device Registry (Section 2521, p. 1001)

53. Grants for labor-management programs for nursing training (Section 2531, p. 1008)